

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Charles 15492STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City Mc Conchie (No. 79) St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Francis Jane Bardroff

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Oct. 3<sup>rd</sup>, 1862  
(Month) (Day) (Year)

7 AGE 52 yrs. 11 mos. 24 ds. If LESS than 1 day, hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9 BIRTHPLACE  
(State or country)Balto. County

10 NAME OF FATHER Snowden Disney  
11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Belt

13 BIRTHPLACE OF MOTHER (State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E. Bardroff(Address) Mc Conchie, Md.

15 Filed Sept 30, 1915 W. H. Thompson REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 29, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1915, to Sept 28, 1915.

that I last saw him alive on Sept 28, 1915.and that death occurred on the date stated above, at 6 P m.

The CAUSE OF DEATH\* was as follows:

Valvular disease of Heart  
about 30 yrs. mos. ds.  
(Duration)

Contributory  
Secondary

(Signed) Thos. J. Owen, M. D.  
Sept 30 1915 (Address) La Plata Md

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Rest Cem DATE OF BURIAL Sept 30, 1915

20 UNDERTAKER Wm R. Clarke ADDRESS La Plata

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

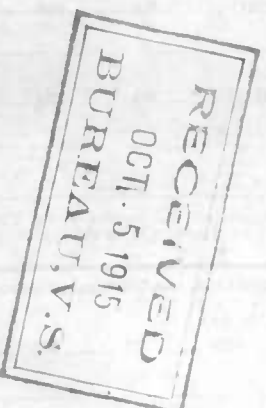
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

15493

County CharlesVillage or City Romfield (No. 151)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 105

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Jones Brooks

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDDED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept. 25, 1915  
(Month) (Day) (Year)

7 AGE 30 yrs. 0 mos. 0 ds. If LESS than 1 day, 30 hrs. OR 30 min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work ✓  
(b) General nature of industry business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Maryland

PARENTS  
10 NAME OF FATHER Dennis J. Brooks  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Mary Eugenia Jones  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cecilia Jones(Address) Romfield, Md.15 Filed Sept 25, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1915, to Sept 25, 1915, that I last saw him alive on Sept 25, 1915, and that death occurred on the date stated above, at 6 A. m.

The CAUSE OF DEATH\* was as follows: Premature Birth

Contributory  
Secondary

(Signed) J. Douglas Crane, M. D.  
Sept 25, 1915 (Address) La Plata, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 30 yrs. 0 mos. 0 ds. In the State, 30 yrs. 0 mos. 0 ds.  
Where was disease contracted, If not at place of death?  
Former or usual residence La Plata, Md.

19 PLACE OF BURIAL OR REMOVAL St. Joseph Cemetery DATE OF BURIAL Sept 25, 1915

20 UNDERTAKER Wm. Jones ADDRESS Romfield, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

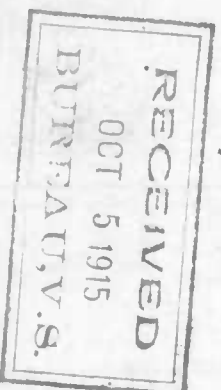
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *pneum-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhina," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS or INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Charles 15494  
Village or City Groesides (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)  
2 FULL NAME Samuel Dent

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 102

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Unknown, 1837  
(Month) (Day) (Year)

7 AGE 78 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR \_\_\_\_\_ min. ?  
If LESS than 1 day, \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work. Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Charles Co. Md.

10 NAME OF FATHER George Dent

11 BIRTHPLACE OF FATHER (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Maria (Ant)

13 BIRTHPLACE OF MOTHER (State or country) Charles Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam. Dent

(Address) Groesides, Md.

15 Filed Sept 29, 1915 Wm B Thompson  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 28, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1915, to Sept 26, 1915.  
that I last saw him alive on Sept 26, 1915.

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:  
Ac. Ascending Paralysis

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) G. C. Bicknell, M. D.  
Sept 28, 1915 (Address) Rising Sun, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Antelope Church DATE OF BURIAL Sept 30, 1915

20 UNDERTAKER Wm B Thompson ADDRESS Doncaster Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

15495

County CharlesSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 104Village or City Essex (No. 104) St.        Ward       

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Agnes M. Donley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH 3-26, 1915  
(Month) (Day) (Year)7 AGE 6 yrs. 6 mos. 1 ds. If LESS than 1 day,        hrs. OR        min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)       9 BIRTHPLACE (State or country) Chas. Co., Md.

PARENTS	10 NAME OF FATHER <u>Joseph Donley</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Chas. Co., Md.</u>
	12 MAIDEN NAME OF MOTHER <u>Mary Burroughs</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Chas. Co., Md.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Donley  
(Address) Essex15 Filed Sept. 28, 1915 J. L. Higdon  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9-27, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from       , 191      , to       , 191      ,that I last saw him        alive on       , 191      and that death occurred on the date stated above, at 9 p.m.

The CAUSE OF DEATH\* was as follows:

Cholera Infantis(Duration)        yrs. 4 mos.        ds.Contributory  
Secondary(Duration)        yrs.        mos.        ds.(Signed) J. L. Higdon, M. D.  
Sept. 28, 1915 (Address) Essex

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.Where was disease contracted, If not at place of death?       Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

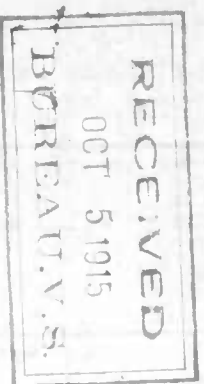
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 15496

County CharlesVillage or City Spring Hill (No. 64)Registration Dist. No. 100

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sarah Smoot Frederick

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Unknown  
Sept. 27th, 1915  
(Month) (Day) (Year)

7 AGE about  
56 yrs. mos. ds. OR 1 day. hrs. min. ?  
It LESS than

8 OCCUPATION Housewife  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer) housewife

9 BIRTHPLACE (State or country) Charles Co

10 NAME OF FATHER Phil Smoot

11 BIRTHPLACE OF FATHER (State or country) Charles Co

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (State or country) Charles Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Isaac Frederick

(Address) Spring Hill, Md.

15 Filed Sept 29, 1915 Hathorn J. Cox  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 27th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1915, to Sept 27, 1915.  
that I last saw her alive on Sept 27, 1915

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
Paralysis (2nd stroke)  
First about 2 yrs ago  
Last " 5 days  
(Duration) yrs. mos. ds.  
Contributory  
Secondary

(Signed) Thos. J. Bowen, M. D.  
Sept 28, 1915 (Address) La Plata, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Mt Hill DATE OF BURIAL Sept 29th, 1915

20 UNDERTAKER Lomax & Penn ADDRESS La Plata

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital"), "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Hæmorrhage," "Paralysis," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH

15497

County CharlesVillage or City Rock Point (No. 104)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 104

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME no name

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, single WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH 5 - 27 - 1915  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ yrs. 4 mos. 29 ds. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Charles Co. Ind.

10 NAME OF FATHER Thomas G. Jackson

11 BIRTHPLACE OF FATHER (State or country) Chas. Co. Ind.

12 MAIDEN NAME OF MOTHER Mary E. Furbush

13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas G. Jackson

(Address) Rock Point

15 Filed Sept. 28, 1915 L. C. Haddon REGISTRAR /

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 - 26 - 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1915 to Sept. 26, 1915

that I last saw him alive on Sept. 25, 1915

and that death occurred on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH\* was as follows:

Illeg. Child

(Duration) \_\_\_\_\_ yrs. 1 mos. 12 ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) L. C. Haddon, M. D.  
Sept. 28, 1915 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
OCT 5 1915  
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

15498

County

Charles

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

100

Village or City

near La Plata

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Frank Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

married

6 DATE OF BIRTH

about

1935

(Month)

(Day)

(Year)

7 AGE

about 80

yrs.

mos.

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Charles Co

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

— 11 —

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Chas. Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lennie Gant

(Address)

La Plata Md

15

Filed

Sept 3, 1915

Kathryn Cox

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept

(Day)

2, 1915

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 24, 1915, to Sept 1, 1915

that I last saw him alive on Sept 1, 1915

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH\* was as follows:

General debility due to old age

(Duration) 1 yrs. mos. ds.

Contributory  
Secondary

(Duration) 1 yrs. mos. ds.

(Signed)

Thos. S. Owen, M. D.

Sept 3, 1915 (Address) La Plata Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Cem, Sept 4, 1915

20 UNDERTAKER

ADDRESS

J. M. Clarke La Plata

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

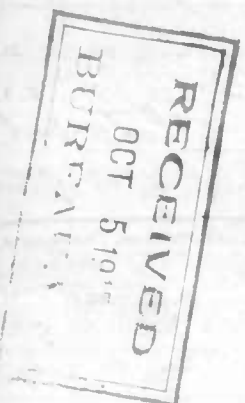
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-ferential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For YO-LENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-*  
*dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

If this certificate is looked over thoroughly and all ques-tions answered in detail, it will prevent further correspond-ence. All the data is essential and must be obtained before the certificate is permanently filed.



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## 1 PLACE OF DEATH

15499

County CharlesVillage or City McConchie (No. 189)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 2

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Henry M. Clements

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

Colored5 SINGLE, MARRIED, WIDOWED OR DIVORCED  
(Write the word)

## 6 DATE OF BIRTH

Oct 13, 1914  
(Month) (Day) (Year)

## 7 AGE

11 yrs. 11 mos. 11 ds.If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

## PARENTS

## 10 NAME OF FATHER

## 11 BIRTHPLACE OF FATHER

(State or country)

## 12 MAIDEN NAME OF MOTHER

## 13 BIRTHPLACE OF MOTHER

(State or country)

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Warren(Address) McConchie

## 15

Filed Sept 27, 1915B. C. Barnes  
Dix-land REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept 23, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:

Unknown  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

## Contributory

Secondary

(Signed) B. C. Barnes, M. D.  
Sept 27, 1915 (Address) McConchie

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Little ZionSept 27, 1915

## 20 UNDERTAKER

## ADDRESS

Geo WarrenMcConchie

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic muscular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Prenatal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rancher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Charles

15500

(119)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 1031Village or City Waldorf (No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Elmira Victoria Monroe

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)single.

## 6 DATE OF BIRTH

March 16, 1842  
(Month) (Day) (Year)

## 7 AGE

73 yrs. 6 mos. 15 ds.If LESS than  
1 day, \_\_\_\_\_ hrs.  
OR \_\_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

Governess

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country)

Charles Co. Md.

## PARENTS

## 10 NAME OF FATHER

H. D. Monroe11 BIRTHPLACE OF FATHER  
(State or country)Maryland

## 12 MAIDEN NAME OF MOTHER

C. E. Smallwood13 BIRTHPLACE OF MOTHER  
(State or country)Charles Co. Md.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John R. Monroe

(Address)

Waldorf Md.

## 15

Filed 9-30, 1915 M. H. Hickman  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

Sept. 30, 1915  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, that I attended deceased from

Aug. 19, 1915, to Sept 30, 1915,that I last saw her alive on Sept 30, 1915,and that death occurred on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH \* was as follows:

Gastric CatarrhContributory  
Secondaryacute bright disease  
(Duration) 1 yr. — mo. — ds.

(Signed)

J. D. Monroe, M. D.  
Sept 30 1915 (Address) Waldorf Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Oakland Cemetery10-2, 1915

## 20 UNDERTAKER

## ADDRESS

Mr. R. ClarkLa Plata

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (namic origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County

Charles

15501

(A)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

82

Village or City

Nanjemoy

(No.

22

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Samuel Montgomery

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept 17

1915

(Month)

(Day)

(Year)

7 AGE

yrs.

mos.

ds.

If LESS than

1 day.....hrs.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Charles co md

10 NAME OF FATHER

Samuel Montgomery

11 BIRTHPLACE OF FATHER

(State or country)

Charles co md

12 MAIDEN NAME OF MOTHER

Lola Shurib

13 BIRTHPLACE OF MOTHER

(State or country)

Charles co md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel Montgomery

(Address)

Nanjemoy md

15

Filed

Sept 28, 1915

Dr B. Thompson

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 17

1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h

alive on

191

and that death occurred on the date stated above, at

4 P

The CAUSE OF DEATH\* was as follows:

Diph. Cold or pneumonia  
Bronch-pneumonia 260  
This is some the last inform  
ation I can get  
Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Dr B. Thompson

M. D.

Sept 28, 1915

(Address)

Baltimore md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Grove church

Sept 28, 1915

20 UNDERTAKER

ADDRESS

Thomas Craig

Nanjemoy md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

15502

County

Charles

Village or City

Naufragary

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 100

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Smoot Mudock

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

54 yrs.

mos.

ds.

If LESS than

1 day, \_\_\_\_\_ hrs.

OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Luther Mudock

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Laura Hancock

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Brown

(Address)

Naufragary Md.

15

Filed

Sept 13, 1915 Wm B Thompson

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 12<sup>th</sup>, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 17, 1915, to Sept 11<sup>th</sup>, 1915that I last saw him alive on Sept 11<sup>th</sup>, 1915

and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH\* was as follows:

Diabetes  
and mental derangement

(Duration)

yrs.

mos.

ds.

Contributory  
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

S. B. Speake

M. D.

1915

(Address)

Grayton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

In the

State

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home burning Sept 13, 1915

20 UNDERTAKER

ADDRESS

Wm B Thompson Donnelly

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

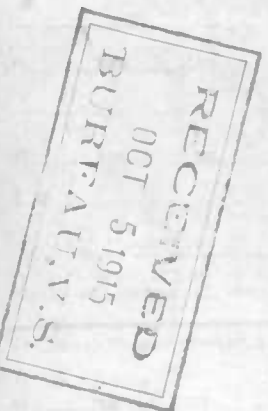
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[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fertal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 4 1915

U. S. DEPT. OF COMMERCE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Chas.

15504

Village or City Dentsville (No. 7)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 107

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Infant Neale

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH Sept. 9, 1915  
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. OR 0 min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Chas. Co.

## PARENTS

## 10 NAME OF FATHER

Manshey Neale11 BIRTHPLACE OF FATHER  
(State or country)Chas. Co.

## 12 MAIDEN NAME OF MOTHER

Marie Thomas13 BIRTHPLACE OF MOTHER  
(State or country)Chas. Co.

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie Neale

(Address)

Dentsville

15

Filed       , 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 9, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

      , 1915 to       , 1915  
that I last saw her dead Sept. 9, 1915

and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH\* was as follows:

still borne(Duration)        yrs.        mos.        ds.Contributory  
Secondary(Duration)        yrs.        mos.        ds.

(Signed)

Jas. E. Delaney, M. D.Sept. 9, 1915 (Address) Bryantown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Neorhome

## DATE OF BURIAL

Sept 9, 1915

## 20 UNDERTAKER

Buried by father (Manshey Neale) Dentsville Md

## ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

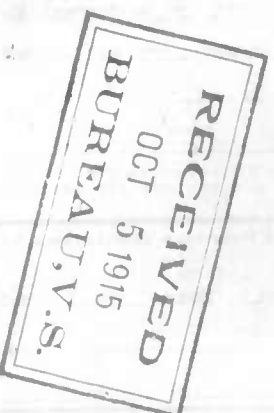
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Charles 15505  
Village or City Newport (No. 96) St.; Ward

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 103

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Anna Lewis

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

6 DATE OF BIRTH Nov. 27, 1915  
(Month) (Day) (Year)

7 AGE 85 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work House keeper  
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Charles Co

10 NAME OF FATHER Perry Nevitt

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Amoot

13 BIRTHPLACE OF MOTHER (State or country) Ma.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Lewis(Address) La Plata Md.

15 Filed 9-7-, 1915 L. S. Herbert

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 6, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1915, to Sept. 6, 1915, that I last saw him alive on Sept. 6, 1915, and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH \* was as follows:  
Bronchial Asthma

Contributory Respiratory (Duration) yrs. 8 mos. ds.  
Secondary Failure (Duration) yrs. 7 mos. ds.  
(Signed) Francis B. Jamerson, M. D.  
9/7, 1915 (Address) Newport

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL Sept. 8, 1915

20 UNDERTAKER A. C. Webb Bros. Chaplains ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (o) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
OCT 4 1915  
BUREAU, V. S.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Charles</u>		15506		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Falckner</u> (No. <u>79</u> )		St.; Ward		Registration Dist. No. <u>103</u>	
2 FULL NAME <u>Louis Practor</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Nov 1st 1880</u> (Month) (Day) (Year)					
7 AGE <u>about 60</u> yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Char. Co.</u>					
PARENTS	10 NAME OF FATHER <u>Tom Jones</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Char. Co.</u>				
	12 MAIDEN NAME OF MOTHER <u>Pug Practor</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Char.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Josephine Mason</u> (Address) <u>Bre Alton</u>					
15 Filed <u>Sept 17</u> , 1915 <u>Chas. H. Roby</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 16</u> , 1915 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>May 20</u> , 1915, to <u>Sept 16</u> , 1915, that I last saw him alive on <u>Sept 4</u> , 1915, and that death occurred on the date stated above, at <u>4 P. m.</u> The CAUSE OF DEATH* was as follows: <u>Chloroform</u>					
Contributory Secondary <u>Organic Weak</u> (Duration) yrs. mos. ds. <u>7</u>					
(Signed) <u>Dr. H. H. H.</u> , M. D. <u>Sept 16</u> , 1915. (Address) <u>Bre Alton</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>St Thomas Church</u> DATE OF BURIAL <u>Sept 18</u> , 1915					
20 UNDERTAKER <u>Chas. H. Roby &amp; Bro</u> ADDRESS <u>Bre Alton</u>					

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

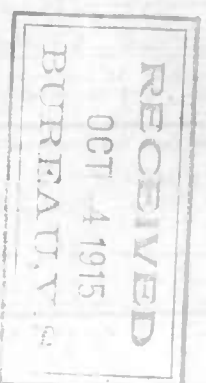
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not eximfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

15507

(No.)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 103

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than  
1 day, hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, that I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH \* was as follows:

Contributory

Secondary

(Signed)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State, yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

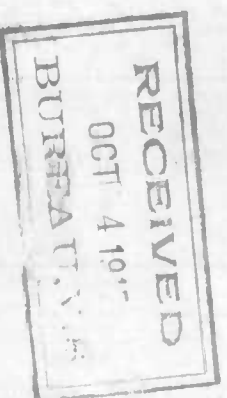
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## 1 PLACE OF DEATH

County Charles 15508STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City Mar La Plata (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Legand Sanders

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH July 23, 1915  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. 1 mos. 22 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Charles Co, Md

10 NAME OF FATHER Ernest Sanders

11 BIRTHPLACE OF FATHER (State or country) Charles Co, Md

12 MAIDEN NAME OF MOTHER Mary Barker

13 BIRTHPLACE OF MOTHER (State or country) Charles Co, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Sanders(Address) La Plata Md

15 Filed Sept 16, 1915 Kathryn J Cox REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1915 to Sept 10, 1915.

that I last saw him alive on Sept 10, 1915.and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH\* was as follows:

Inanition - Cause  
not known

(Duration) since birth yrs. mos. ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Thos S. Owen, M. D.  
Sept 16, 1915 (Address) La Plata Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Newtown DATE OF BURIAL Sept 16, 1915

20 UNDERTAKER Ernest Sanders ADDRESS La Plata Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ignition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (c. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

15569

County CharlesSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City La Plata (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mamie Sewel

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH not known, 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE about 25 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. It LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Chas. Co., Md.

PARENTS  
10 NAME OF FATHER Henry Yates  
11 BIRTHPLACE OF FATHER (State or country) Chas. Co., Md.  
12 MAIDEN NAME OF MOTHER Jennie Yates  
13 BIRTHPLACE OF MOTHER (State or country) Chas. Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Sewel(Address) Mc Conchie

15 Filed Sept 18, 1915 Attorney J. P. H.  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 16, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1915, to Sept 14, 1915,

that I last saw her alive on Sept 14, 1915

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Acute ManiaExhaustion(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Dr. J. S. Owens, M. D.  
Sept 16, 1915 (Address) La Plata, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Mc Conchie DATE OF BURIAL Sept 18, 1915

20 UNDERTAKER Lorray & Penn ADDRESS La Plata

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

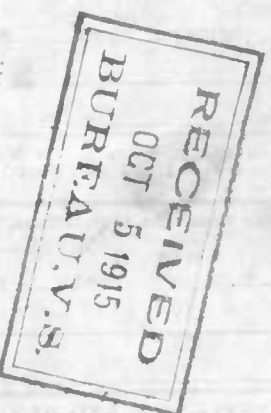
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 15510 (1)  
 County Charles  
 Village or City Fallicker (No. 150) St.; Ward)  
 2 FULL NAME Maurice Short  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 (Write the word)

6 DATE OF BIRTH Not known  
 (Month) (Day) (Year)

7 AGE about 41 yrs. mos. ds. If LESS than 1 day, hrs. min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Not known from Maryland

PARENTS  
 10 NAME OF FATHER Not known  
 11 BIRTHPLACE OF FATHER (State or country) Not known  
 12 MAIDEN NAME OF MOTHER Not known  
 13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Theresa Short

(Address) Baethan

15 Filed Sept 25, 1915 Chas W Roly REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 103

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25, 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1915, to Sept 8, 1915.  
 that I last saw her alive on Sept 8, 1915

and that death occurred on the date stated above, at 2 P. m.  
 The CAUSE OF DEATH\* was as follows:

Chronic Nephritis

(Duration) 1 yrs. 8 mos. ds.  
 Contributory Typhoid Fever  
 Secondary

(Signed) E. J. [unclear], M. D.  
Sept 25, 1915 (Address) Bel Air

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St Thomas Church DATE OF BURIAL Sept 27, 1915

20 UNDERTAKER Chas W Roly & Co ADDRESS Bel Air

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
OCT 4 1915  
BUREAU



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1 PLACE OF DEATH

15511

County CharlesSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City La Plata

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Jane Short

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow  
(Write the word)

6 DATE OF BIRTH

unknown  
(Month) (Day) (Year)

7 AGE

About 72 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)md.

## PARENTS

10 NAME OF FATHER

not known11 BIRTHPLACE OF FATHER  
(State or country)

"

12 MAIDEN NAME OF MOTHER

"

13 BIRTHPLACE OF MOTHER  
(State or country)

"

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Magruder Wallace(Address) La Plata

15

Filed Sept 12, 1915 Nathryn Rex  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 10th, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_.

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_.

and that death occurred on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH\* was as follows:

Asthma

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Dr. T. S. Owen, M. D.Sept 10, 1915. (Address) La Plata, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. to the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brices CemeterySept 13, 1915

20 UNDERTAKER

ADDRESS

Lomax & PennLa Plata

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fertal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæ-mia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIO-LENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-dent*; *Recoiler wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Charles</u>		15512	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Smiths</u> (No. <u>79</u> )		St. _____	Ward _____	
2 FULL NAME <u>David Taze</u>		Registration Dist. No. <u>108</u>		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>		
6 DATE OF BIRTH <u>Unknown</u> , 1 <u>828</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Sept 30</u> , 191 <u>5</u> (Month) (Day) (Year)		
7 AGE <u>87</u> yrs. _____ mos. _____ ds. OR _____ min. ?	If LESS than 1 day, _____ hrs.		17 I HEREBY CERTIFY, That I attended deceased from <u>June</u> , 191 <u>5</u> , to <u>Sept 30</u> , 191 <u>5</u> , that I last saw him alive on <u>Sept 16</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>6 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Organic heart disease</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		Contributory (Secondary) <u>Smoking</u> (Duration) <u>2</u> yrs. _____ mos. _____ ds.		
9 BIRTHPLACE (State or country) <u>Ind</u>		(Signed) <u>J. M. Mott</u> , M. D. (Duration) _____ yrs. _____ mos. _____ ds.		
10 NAME OF FATHER <u>Unknown</u>		(Address) <u>Agnes</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
12 MAIDEN NAME OF MOTHER <u>Unknown</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____		
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind.</u>		19 PLACE OF BURIAL OR REMOVAL <u>Bryantown Ind</u> DATE OF BURIAL <u>Oct 2nd</u> , 191 <u>5</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Robert Taze</u> (Address) <u>Anglicanville</u>		20 UNDERTAKER <u>Geo. Trollen</u> ADDRESS <u>Bryantown Ind</u>		
15 Filed _____, 191 <u>5</u>		REGISTRAR		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

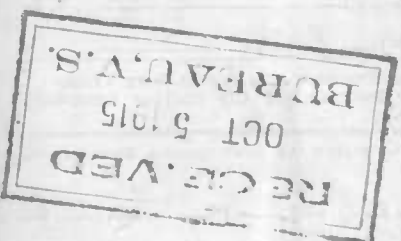
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thema," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

15513

County

Charles

Village or City

Pomonkey

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

Registration Dist. No. 104

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary E. Foye

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Mar 25<sup>th</sup> 1865  
(Month) (Day) (Year)

7 AGE

50 yrs. 5 mos. 27 ds. If LESS than  
1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House work

9 BIRTHPLACE

(State or country)

Md

## PARENTS

10 NAME OF FATHER

James Martin

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Christina King

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Delia Foye

(Address)

Pomonkey

15

Filed

Sept 25 1915 J. P. Marshall  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 22, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Sept 6, 1915, to Sept 22, 1915.

that I last saw him alive on Sept 22, 1915

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:

Nephritis Chronic  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

Edema of lungs  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) M. J. Simmons, M. D.  
9/23, 1915 (Address) Indian Head, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pomonkey Cem.

Sept 25, 1915

20 UNDERTAKER

ADDRESS

Wm. Mahoney

Accotank



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

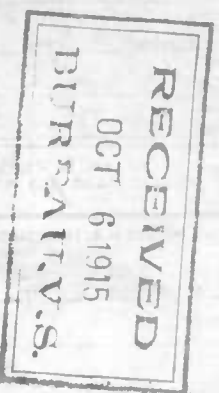
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

15514

County

Charles

Village or City

Pisgah

(No. ....)

St.; .... Ward)

Registration Dist. No. 101

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thelma E. Turner

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 25, 1915

7 AGE

5 yrs. 5 mos. 3 ds.

If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Charles Co Md

10 NAME OF FATHER

Wesley Turner

11 BIRTHPLACE OF FATHER (State or country)

Charles Co Md

12 MAIDEN NAME OF MOTHER

Emma Brown

13 BIRTHPLACE OF MOTHER (State or country)

Charles Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Holzman

(Address)

Pisgah Md

15

Filed

Sept 29, 1915 T.A. Luthersland

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 28, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191...., to

191....

that I last saw him alive on

191....

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:

unknown  
No physician in attendance

(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed) T.A. Luthersland, M.D.

Sept 29, 1915 (Address) Marbury Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smith Cheffell

Sept 30, 1915

20 UNDERTAKER

ADDRESS

Julien Howland

Pisgah Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

15515

County

Charles.

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

106

Village or City

Pisgah

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bernet H. Washington

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

June 30, 1915

7 AGE

3 yrs. 3 mos. ds. If LESS than 1 day, hrs. min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Charles Co. Md

## PARENTS

10 NAME OF FATHER

Charley Washington

11 BIRTHPLACE OF FATHER (State or country)

Charles Co. Md.

12 MARIEN NAME OF MOTHER

Aola B. Queen

13 BIRTHPLACE OF MOTHER (State or country)

Charles Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Inferent)

Madie Queen

(Address)

Pisgah Md

15

Filed Sep 28, 1915

T. W. Wetherland  
Incar REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sep 26, 1915

17

I HEREBY CERTIFY, That I attended deceased from

Sep 24, 1915, to Sep 26, 1915, that I last saw him alive on Sep 25, 1915

and that death occurred on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cholera Infantum

Contributory Secondary

(Duration) yrs. mos. ds.  
(Signed) G. E. Bicknell, M. D.  
Sep 27, 1915 (Address) Pisgah Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Smith Chapel Sep 26, 1915

20 UNDERTAKER

ADDRESS

C. C. Carpenter Pisgah Md

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